Kentucky Diabetes Connection

The Communication Tool for Kentucky Diabetes News

AACE
American Association of Clinical Endocrinologists Ohio Valley Chapter

ADA
American Diabetes Association

DECA
Diabetes Educators Cincinnati Area

GLADE
Greater Louisville Association of Diabetes Educators

JDRF
Juvenile Diabetes Research Foundation International

KADE
Kentucky Association of Diabetes Educators

KEC
Kentuckiana Endocrine Club

KDN
Kentucky Diabetes Network, Inc.

KDPCP
Kentucky Diabetes Prevention and Control Program

TRADE
Tri-State Association of Diabetes Educators

A Message from Kentucky Diabetes Partners

According to numerous individual contacts and positive comments received by email, phone, and in person, the *Kentucky Diabetes Connection* has been a big success in providing useful diabetes information! Nearly 800 copies of the premier issue of this newsletter were mailed in January 2005 to board of directors or members of Kentucky diabetes entities. Many additional diabetes professionals have also requested to be added to this newsletter mailing list. Plans are to have quarterly newsletter issues mailed or emailed in January, April, July, and October of each year.

The *Kentucky Diabetes Connection* has been accepted as a poster session at the Centers for Disease Control and Prevention (CDC), Diabetes Translation Conference, to be held in Miami, FL, May 2-5. In addition, this newsletter was featured in a public health newsletter of the American Association of Diabetes Educators (AADE) and has also been accepted as a presentation at the annual meeting of the American Association of Diabetes Educators to be held in Washington D.C. in August, 2005.

The first issue of this newsletter is now available as a PDF file and will soon be placed on the KDPCP and or the KDN website (to which other organizations can link). Please note that the KDPCP website has recently been updated and it is now www.chfs.ky.gov/dph/ach/diabetes (the KDPCP web address originally on the back of this newsletter is no longer active).

The database design for sending out this newsletter by regular mail or email is still being perfected. Thus copies will continue to be sent by regular mail until this process is completed.

We hope you enjoy the second edition of the *Kentucky Diabetes Connection*! Inside this issue you will find articles regarding new funding for diabetes in Kentucky, a new law regarding glucagon usage in KY schools, results of Kentucky kidney screenings, a new Kentucky fact sheet on sharps disposal, new diabetes initiatives by KY Medicaid, and much more!!

Please continue to support this new communication endeavor by offering diabetes articles and information to Janice Haile at janice.haile@grdhd.org or call 270-686-7747 ext. 5562.

COMING SOON TO A SCHOOL NEAR YOU:
CHANGES IN THE SCHOOL NUTRITION AND PHYSICAL ACTIVITY ENVIRONMENT

By Tonya Chang, RN, and Carolyn Dennis, RD

After four years of debate and an outpouring of public support, Kentucky lawmakers finally passed a school nutrition and physical activity bill during the 2005 session of the General Assembly. Kentucky is one of many states in recent years that have considered policy changes in schools in response to the dramatic increase in childhood obesity.

Childhood obesity has reached epidemic proportions nationally and in Kentucky. In the last twenty years, the rate of overweight has more than doubled in children and has nearly tripled in adolescents. Kentucky high school students have the third highest rate of overweight in the country.

Even Kentucky's youngest citizens are affected. It is estimated that seventeen percent of 2 to 4 year-olds in Kentucky are overweight. The issue of a child's weight has nothing to do with vanity and everything to do with health. Being overweight puts children at an increased risk for developing a host of chronic health problems including high blood pressure, high cholesterol and type 2 diabetes.

Recognizing the important role that schools play in helping shape children's behaviors and the need for schools to serve as positive role models, many parents and health advocates have called for changes in the school nutrition and physical activity environment. In the past, these efforts have met with much resistance from snack food and beverage interests and even some in the education community. Some feel that schools are being singled out to blame for childhood obesity.

While we do not blame the schools, we do see a real opportunity for schools to serve as catalysts for positive change. Although there was some strong opposition again this year, we were able to help secure passage of a meaningful piece of legislation related to school nutrition and physical activity.

Senate Bill 172:

- **Bans soft drink sales in elementary schools during the school day;**
- **Allows elementary schools during the school day to sell water, juice, low-fat milks (plain or flavored) and other beverages that contain less than 10 grams of sugar per serving;**
- **Limits retail fast food in cafeterias to once a week;**
- **Requires the school food service director or other person who is responsible for meal planning to become credentialed or certified by the national School Nutrition Association;**
- **Requires 8 hours annually of nutrition education for school food service directors and 2 hours for cafeteria managers;**
- **Requires an annual report on the school nutrition and physical activity environment (the report will be issued to parents, the school-based council and the local board of education);**
- **Requires local school-based councils in elementary schools (or the school principal in cases where elementary schools don't have a school-based council) to develop and implement a wellness policy that includes daily physical activity. Allows up to 30 minutes a day or 150 minutes a week of the physical activity to be included as instructional time;**
- **Establishes penalties for competitive food violations; and**
- **Requires the KY Board of Education to promulgate regulations that address the nutritional content of foods and beverages sold in school stores, vending machines, canteens and ala carte cafeteria sales.**

Some of these changes will be apparent beginning in the next school year, while others will be implemented following the development of administrative regulations. Although legislation has passed, advocates must continue this effort during the regulatory process with the state Board of Education as they promulgate regulations on competitive foods and ala carte cafeteria items in schools.

There is a tremendous opportunity in KY to improve the nutritional offerings in schools but special interests may make this endeavor as challenging as getting legislation passed.

Everyone interested in changing the school food environment must continue to voice concern to state school board members, principals and school-based council members to insure that adequate changes occur and are implemented in every school.

Will these changes alone reverse the obesity epidemic? No, but collectively these changes are an important first step in the right direction.

The legislators who worked tirelessly and passionately on behalf of these efforts deserve special thanks. They include Senator Alice Forgy Kerr, Representative Tom Burch, Representative Tim Feeley and Senator Ernesto Scorsone.

Schools cannot bear this responsibility alone. Changes must also occur at home. Making healthy choices isn't always easy. Living a healthy lifestyle truly is a journey and not a destination; we all need to take this journey together.

If you would like additional information about Senate Bill 172 or how you can get involved, please contact Tonya Chang at tonya.chang@heart.org or Carolyn Dennis at carolyn.dennis@adelphia.net .

Every Child Deserves a Good School Lunch

DIABETES DAY AT THE CAPITOL SUCCESSFUL IN EDUCATING LEGISLATORS ABOUT DIABETES AND SECURING MORE MONEY FOR KENTUCKY DIABETES PREVENTION AND CONTROL!!!!

Deborah Fillman RD, CDE
KDPCP regional staff, KDN & TRADE member

The Kentucky Diabetes Network (KDN), the American Diabetes Association, the Juvenile Diabetes Research Foundation, Diabetes Educator Chapters, KY Diabetes Coalitions, endocrinologists and other KY diabetes advocates pooled their many resources and became successful in educating legislators regarding diabetes and securing $900,000 additional state dollars for diabetes prevention and control activities in Kentucky!! KDN and partners held the third annual *"Diabetes Day at the Capitol"* on February 8, 2005 with 88 diabetes advocates in attendance. This was the first increase in state diabetes funding in 25 years!

Many, many diabetes advocates took part in educating legislators about Kentucky diabetes needs—which resulted in making this new funding a reality. There were 750 letters of invitation mailed to members of KDN, TRADE *(KY Members)*, KADE, GLADE, DECA *(KY Members),* KY Endocrinologists and KY Coalitions. Fifty-seven individual visits *(an increase from 48 individual visits last year)* were made with Kentucky legislators. AND every single legislator (a total of 138) was contacted through either individual visits or via legislative diabetes education packets.

As a result of the new funding, a meeting with approximately 20 diabetes professionals and local health department staff, was held on April 7th in Frankfort by the Kentucky Department for Public Health. This meeting was held to garner input and recommendations regarding the distribution of the new funds to increase Kentucky's diabetes prevention and control initiatives.

The importance of your involvement in the legislative process whether at a federal, state or local level cannot be underestimated. Plan today to attend Diabetes Day at the Capitol 2005!!!

Diabetes Advocates Educate Legislators At Diabetes Day At The Capitol

(Above) Members of the Madison County Diabetes Coalition And Eastern KY University (EKU) nursing students meet with Representative Harry Moberly at the 2005 Diabetes Day at the Capitol in Frankfort, February 8, 2005 (photo submitted by Kim DeCoste).

Members of the Daviess County Diabetes Coalition (DCDC) meet with Senator David Boswell (Top right) and Representative Tommy Thompson (bottom right) at the Diabetes Day At the Capitol (photos submitted by Cindy Mattingly, DCDC President Elect).

ELIMINATING HEALTH DISPARITIES

Julia Richerson, MD
Medical Director of Family Health Centers
A Federally Qualified Health Center, Louisville, KY

"Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or injury." Quote, the World Health Organization

A top priority at Family Health Centers is working toward the elimination of health disparities. “Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases that exist among specific population groups in the United States.” These population groups may be characterized by gender, age, ethnicity, education, income, social class, disability, geographic location, or sexual orientation (as defined by the National Institutes of Health).

If we eliminate disparities, people who are in minority populations or who are poor will experience a better overall standard of health, with less death, sickness and suffering from diseases like **diabetes**, depression, heart disease and asthma.

It is important to note that very little has changed in how the health care system has cared for patients in the last 50 years. We have new medicines and new treatments, but how we approach the patient has remained essentially unchanged. And the old system does not work. If we want our patients to be healthier, we must transform what we do every day.

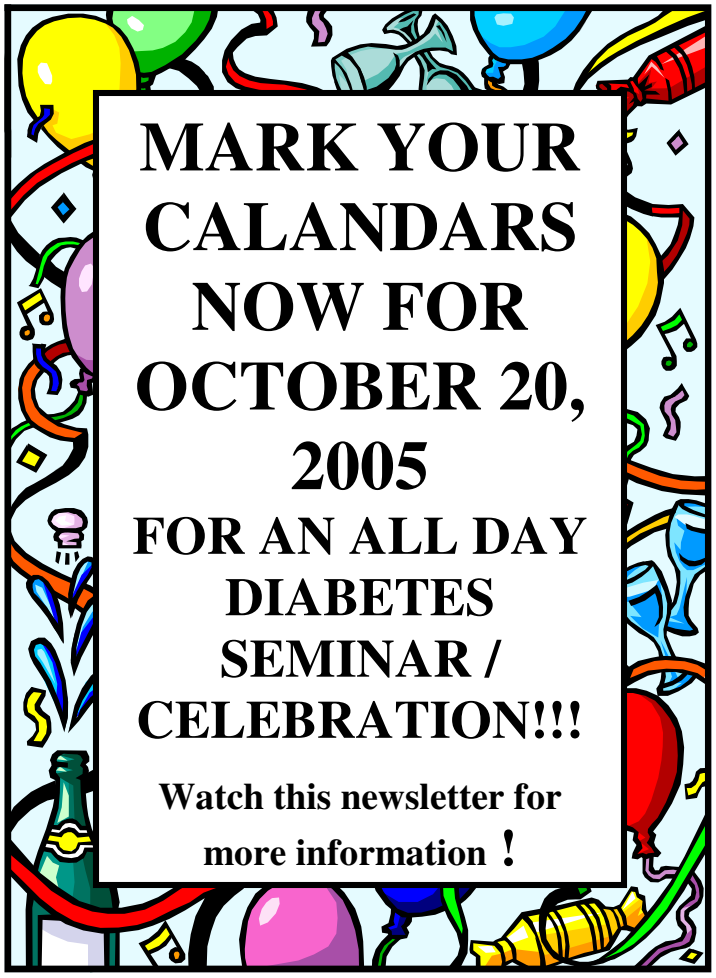
To achieve the elimination of health disparities, the entire health care delivery system must change the way health care is delivered. Our clinic and staff are working in partnership with other Community Health Centers across the country to do this.

At the Family Health Centers in Louisville, we are well underway with a process called the Health Disparities Collaboratives. Using this process is how we are transforming how we deliver health care.

The Patients: We have improved the way we partner with patients in their health. We help them to understand their illness and their role to play in controlling their health, including setting goals to improve their health behaviors like exercise, healthy eating, and taking their medicines.

The Health Care Team: Doctors, nurse practitioners, social workers, pharmacists, nursing staff, registration staff, lab staff and all members of the Family Health Center team have changed the way they approach taking care of the patient. We use the best possible medical evidence about how we should take care of patients and apply it every time, to every patient, from the time they enter the clinic to the time they leave.

By applying these new concepts, we are transforming our current health care system and are excited about the opportunities we have to work toward eliminating health disparities. We are very proud of the high quality of health care our patients receive!



DO YOU HAVE QUESTIONS ABOUT HOW TO BECOME A CERTIFIED DIABETES EDUCATOR?

If you have questions about how to become a certified diabetes educator, contact:

National Certification Board for
Diabetes Educators
330 East Algonquin Road, Suite 4
Arlington Heights, Illinois 60005
Voice 847 228-9795
Fax 847 228-8469
Email info@ncbde.org

Next Test Date is
October 29
(application Deadline July 15th)

KENTUCKY KIDNEY DISEASE SCREENING RESULTS

Lisa Allgood
National Kidney Foundation of Kentucky

According to recent research published in the American Journal of Kidney Diseases, nearly half the people with an advanced form of kidney disease do not know it!

Over the past decade, the number of people with kidney failure doubled and the number starting dialysis or having a first kidney transplant increased by 50 percent, so that more than 400,000 Americans are now being treated for kidney failure at a cost of $25 billion annually.

Diabetes is the leading cause of kidney failure. End stage renal disease is expected to double by 2010 primarily because of the rise in diabetes and hypertension! Given the high prevalence of chronic kidney disease, it has become imperative to increase awareness, diagnosis and treatment to reduce the rate of kidney disease and its complications.

There are over 500 Kentuckians awaiting kidney transplants and just last year over 2000 people were diagnosed with chronic kidney disease in the state of Kentucky.

The National Kidney Foundation of Kentucky is committed to increasing awareness of chronic kidney disease. The Kidney Early Evaluation Program (KEEP) is a free health screening program offered for individuals at increased risk of developing kidney disease.

Since June of 2004, the National Kidney Foundation of Kentucky screened 372 participants in Kentucky for early signs of chronic kidney disease. Kentucky screening sites included: Louisville Urban League (73 participants), Westside Medical Center/Caritas (49 participants), Elderserve (54 participants), UK Applachian Regional Medical Center (86 participants), Daviess County Diabetes Coalition (40 participants), Bowling Green Diabetes Today Coalition (70 participants). The screening results are staggering and are as follows:

- **71% learned they may have kidney disease**
- **11% learned they may have hypertension**
- **5% learned they may have diabetes**
- **100% of participants had at least one value outside a normal range (abnormals were defined as blood pressure ≥ 120/80; fasting blood glucose ≥ 126 or random blood glucose ≥ 140; microalbuminuria 30 mg/L or greater; albumin to creatinine ratio 30 mg/gm or greater; pyuria positive; hematuria positive; hemoglobin < 12 gm/dl female or < 14 gm/dl male; estimated glomerular filtration rate ≤ 90 ml/ min/1.73m2)**

Of those screened, 35% were already aware they had diabetes and 59% were already aware they had hypertension. Unfortunately, as is consistent with research, many of those same individuals who already knew they had diabetes or hypertension did not know that they were at higher risk for kidney disease!

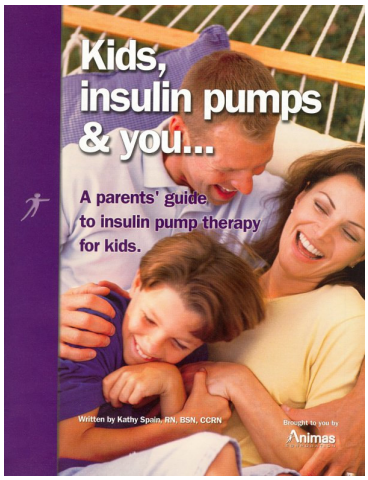
African Americans are disproportionately represented in the numbers of chronic kidney disease. In Kentucky, 46% of the screening participants were African American. Access to high risk populations was made possible by partnerships with the Louisville Urban League, diabetes educators via local health departments, and Elderserve.

The KEEP program provides valuable information to participants as well as follow up. The National Kidney Foundation of Kentucky is also committed to providing screenings throughout the state in 2005. Kidney screening sites scheduled for Kentucky in 2005 thus far include: 2-17-05 Harlan Medical Center, 3-19-05 Louisville Metro Health Department, 4-2-05 Henderson County Diabetes Coalition, 4-28-05 Madisonville, 5-24-05 Dosker Manor (Louisville), William Weathers (Louisville), and Oak and Acorn (Louisville).

As with any large program, funding is vital. Kentuckians can donate a car, truck, van, boat, motorcycle, etc. to the National Kidney Foundation's Car Program to help fund research, public education, patient services, health fairs, free screenings and promotion of organ / tissue donation.

If you would like additional information regarding how to schedule a screening in your area, please contact Lisa Allgood at 502-585-5433 or lallgood@nkfk.org

FREE… RESOURCE FOR USING INSULIN PUMPS IN CHILDREN



Get a FREE complimentary copy of the book, *Kids, Insulin Pumps and You: A Parents' Guide to Insulin Pump Therapy for Kids,* by contacting Animas Corporation, Bill King, toll-free 877-937-7867 Ext. 1132 or email bill.king@animascorp.com

KENTUCKY MEDICAID BEGINS NEW DIABETES INITIATIVE

Donna Chapman
Kentucky Department for Medicaid Services

Diabetes is a controllable disease; therefore, chosen as the target of the first initiative and Disease Management program for the Cabinet for Health and Family Services, Department for Medicaid Services, Division of Medical Management/Quality Assurance. The two selected pilot counties, Bell and Floyd, were chosen because they were identified through Medicaid data as having the highest incidence of diabetes in the state. The Disease Management / Case Management process will be based on the "Standard of Care and Guidelines" set forth by the American Diabetes Association.

Diabetes is the fourth most common co-morbid condition complicating all KY hospital discharges. In 1997, diabetes was present in 9.5% of all Medicaid hospital discharges and two of every five cardiac surgeries. Diabetes causes a twofold increase in rates of hospitalizations and increases hospital length of stay by 1 to 3 days, depending on the admitting diagnosis.

Diabetes is a serious disease in KY and is the fifth leading cause of death by disease in all Kentuckians, and the fourth leading cause of death by disease in African American Kentuckians. Diabetes is a costly disease accounting for:

- 91,088 diabetes-related hospitalizations in 2001
- 30,059 hospitalizations (33%) due to circulatory disease in 2001 (estimate)
- 4,070 hospitalizations due to pneumonia and influenza in 1998
- 2,466 hospitalizations due to diabetic ketoacidosis in 2001
- 1,197 hospitalizations with a lower extremity amputation in 2001

Phase I of the new Medicaid and Diabetes Initiative will include letters to providers introducing and informing them of the upcoming program in these two counties. Medicaid will ask for provider input and assistance in the collection of data, identification of members at risk, as well as suggestions regarding treatment plans for identified members. Risk assessment tools and education materials will be shared with providers to assist in the treatment of their patients. Identified members will receive a letter explaining the program and empowering them to take an active role in their own healthcare.

Phase II of the Medicaid and Diabetes Initiative includes utilization of both in-house and regional registered nurse staff, who are certified in case management, to assist the members, providers, and other involved parties in the day to day activities of the program. The two on site physicians will assist in insuring that goals of the program are met and exceeded. These goals will include:

1. Improve the health of Kentucky's diabetic population
2. Decrease hospitalization of diabetic recipients
3. Establish/maintain a self-management program for diabetic members
4. Decrease Diabetic retinopathy
5. Decrease nephropathy
6. Decrease lower limb amputation

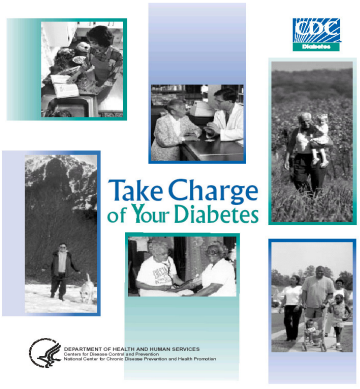
Phase III of the Medicaid and Diabetes Initiative will include sharing reported program outcomes with all parties involved for continued improvement in the Diabetes Disease Management Program.

The State of Kentucky is devoted and committed to improving the lives of Kentuckians by delivering quality cost effective services that enhance the health, safety, and well-being of all people in the Commonwealth of Kentucky.

KENTUCKY MEDICAID BEGINS PAYING FOR HOSPITAL BASED DIABETES EDUCATION

According to Jason Mulligan, Director of Hospital and Provider Operations, KY Department of Medicaid, "KY Medicaid is now paying for diabetes education when performed on an outpatient basis with the entire service billed by the hospital under the hospital provider number. Allowable CPT codes include G0108 and G0109. Diabetes education offered through other entities are not being covered by Medicaid at this time."

FREE…
TAKE CHARGE OF YOUR DIABETES



This book by CDC is public domain. You may download and copy (unlimited) this "Take Charge of Your Diabetes" book by logging onto
http://www.cdc.gov/diabetes/pubs/tcyd/index.htm
You may also call toll free 1-877- CDC-DIAB (232-3422) for a free copy of this book (and others).

PUBLIC FORUMS SUGGEST HEALTH INSURANCE UNAFFORDABLE TO MANY KENTUCKIANS

David A. Gross
Director of External Affairs
University of Kentucky, Center for Rural Health, Hazard, KY

Health insurance has become simply unaffordable for a substantial segment of the population in Kentucky, a series of public forums suggest. And as premiums soar, small businesses, small cities, hospitals, nonprofit and charitable organizations, and other community institutions are feeling the pinch as they find it more and more difficult to retain health care as a benefit.

Those were among the findings of a recently completed series of 15 forums held around the state aimed at engaging public dialogue about the problem of under- and uninsurance in Kentucky.

A $713,000 federal grant, awarded last September to the State Office of Rural Health, funded the Kentucky Health Insurance Research Project. Representatives from the Universities of Kentucky and Louisville and the Kentucky Long-Term Policy Research Center have since been exploring public and private means for expanding coverage to the state's approximately 576,000 uninsured residents.

One of the first steps in that process was to hold public forums in each of Kentucky's area development districts. Project Director Michal Smith-Mello said the forums revealed that:

♦ The population of underinsured and what social scientist Rose Weitz calls the "perilously" insured (those who could not afford to meet their portion of the costs of a health incident without compromising basic needs or those who will not be able to sustain insurance coverage) might be as large, if not larger, than those who are completely without health insurance.

"Perhaps at greatest risk," Smith-Mello said, "are older but not-yet-Medicare-eligible Kentuckians, who retired early, sometimes for health reasons, or lost often longstanding sources of employment and were forced into marginal jobs. Due to their ages and health conditions, many are being priced out of the insurance market."

♦ Premium increases — some reportedly as high as 20 to 30 percent over consecutive years — are cutting into the profits of small employers and the operating funds of city governments, hospitals, nonprofit organizations, and other community institutions.

"As a result, some mayors report that they may have to cut employees or raise the cost of the very benefits that enable them to recruit employees to relatively low-paying jobs," Smith-Mello said.

♦ The issues related to under- and uninsurance are having and will continue to have a dramatic effect on the state's economic well-being.

Said Smith-Mello: "The insurance costs reported by providers, institutions, employers and individuals, and the adverse impact on employers — both public and private — are so substantial that it is logical and reasonable to conclude that the Commonwealth may be losing considerable revenue as the disposable incomes of those who are buying insurance or paying for it out of pocket."

♦ Some insurers routinely delay reimbursement; deny certain diagnostic tests outright and without exception, regardless of the reason for the test; and delay credentialing for as much as six months, which means newly hired doctors — some in underserved areas — cannot be reimbursed for work that otherwise would be covered.

♦ And, the protections intended to shield people from becoming uninsured are not working. COBRA benefits and Kentucky Access, a state-run high-risk pool, both reportedly are very costly, and Medicaid's safety net has been substantially weakened. Smith-Mello said several forum attendees reported that they had difficulty finding doctors in their area who would take Medicaid patients while some said that physicians treated Medicaid recipients differently than private-pay insurance patients. Additionally, some providers reported that higher and more frequently required burdens of proof of eligibility pose real obstacles in some communities.

The next phases of research include a survey of small businesses, those employing fewer than 50 people; a general population survey with an emphasis on the uninsured; an economic analysis of the cost of uninsurance to the Commonwealth; and small group meetings with the uninsured.

For questions or more information, contact Michal Smith-Mello, Project Director, Kentucky Health Insurance Research Project, 800-853-2851 or 502-564-2851, michal.mello@lrc.ky.gov or suzanne.king@lrc.ky.gov .

LOUISVILLE AREA EDUCATORS HOLD FORUM REGARDING DIABETES CARE IN KENTUCKY SCHOOLS

Eloise Campbell, NP, CDE (GLADE Member)
Joslin Diabetes Center, Floyd Memorial Hospital, IN

The Greater Louisville Association of Diabetes Educators (GLADE), one of four Kentucky chapters of the American Association of Diabetes Educators (AADE), have been concerned regarding the diabetes care of children within Kentucky schools. In December 2004, GLADE sponsored a panel discussion regarding "Diabetes and the School Age Child." The panel members included: Stewart Perry, American Diabetes Association (ADA), Government Relations; Larry Smith, ADA National Advocacy Council; Francine Haddad, ADA National Advocacy Field Director; Vasti Broadstone, MD Endocrinologist; Pam Clark, MD, Pediatric Endocrinologist; Bernadette Sutherland, RN, KY Board of Nursing; Laura Donahue, Jefferson County Public School Board; and Phyllis Gentry, School Nurse Association. Eloise Campbell, NP, CDE served as facilitator.

The 60 people in attendance represented local, state and federal health professionals and citizens concerned with the "diabetes care in schools" issue.

The meeting had the following three priorities:

- First, was to increase knowledge about diabetes in community leaders and policy-makers.
- Second, was to provide a mechanism for collaboration and networking among involved parties.
- Third, was to initiate dialogue on potential solutions for obtaining a consistent and safe environment in the schools for children with diabetes.

Overall, it was an excellent program to initiate discussion. Federal laws that protect children with diabetes include: Section 504 of the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act of 1991, and the Americans with Disabilities Act. Under these laws, diabetes has been considered a disability, which means that it is illegal for schools and day care centers to discriminate against children with disabilities. In addition, any school that receives federal funding must reasonably accommodate the special needs of children with diabetes.

As professionals who see families and children with diabetes on a daily basis, we need to ensure that parents are aware of the importance of having an individualized Diabetes Medical Management Plan on file at school. Diabetes and school resources (diabetes education and discrimination packets) are available from the ADA by calling 1-800-DIABETES.

The last question in the panel discussion was, "What comes next?" **As a result of this forum, Deborah Ballard, MD, worked with Senator Julie Denton, (R) Louisville, to draft legislation regarding the usage of glucagon in schools. The result is that a new law was passed in Kentucky (see article, *New Law Deals with Glucagon Usage in Kentucky Schools).***

Also a statewide committee is beginning to collect data and follow legislation regarding diabetes and school issues. This newly formed committee will also work to keep interested parties informed. For more information, contact: Kim Jackson 502-574-6663 Kimberly.Jackson@loukymetro.org (for Louisville area) or Kathleen Stanley 859-260-6674 kstanley@BHSI.com (Lexington area).

NEW KENTUCKY LAW DEALS WITH GLUCAGON USAGE IN SCHOOLS

Stewart Perry, Chair National American Diabetes Association, Advocacy Committee

We have all heard about how politicians pass bad bills in "*the dark of night*" --- this time, however, it worked in our favor! Senator Julie Denton, (R) Louisville, sponsored a bill that has now become law that deals with glucagon usage in schools.

The following excerpt was taken from the KY Legislative Record Website for HB 88: "a school district and its employees have immunity from any injury sustained by a student from any reaction to any hypoglycemic or seizure medications or its administration and that a parent shall hold harmless the school and its employees against any claims made for any reaction to any medications or the administration thereof to treat a hypoglycemic episode or seizure; add that glucagon may be administered at school for hypoglycemia or other conditions noted in the health care practitioner's written statement; clarify that a school employee is not required to consent to administer glucagon or diazepam rectal gel to a student if the employee does not otherwise consent to provide the health service under KRS 156.502."

In addition, the hyperlink section of HB 88, scroll down to the FCCR link reads:

"(1) The board of each local public school district and the governing body of each private and parochial school or school district shall have at least one school employee at each school who has met the requirements of KRS 156.502 on duty during the entire school day to administer the following medication in an emergency:

(a) Glucagon subcutaneously, using a glucagon emergency kit, to students with diabetes who are experiencing hypoglycemia or other conditions noted in the health care practitioner's written statement under subsection (2)(b) of this section; and

(b) Diazepam rectal gel in a prefilled unit-dose delivery system.

(2) Prior to administering glucagon or diazepam rectal gel to a student, the student's parent or guardian shall:

(a) Provide the school with a written authorization to administer the medication at school;

(b) Provide a written statement from the student's health care practitioner which shall contain the following information:

1. Student's name;

2. The name and purpose of the medication;

3. The prescribed dosage;

4. The route of administration;

5. The frequency that the medication may be administered; and

6. The circumstances under which the medication may be administered; and

(c) Provide the prescribed medication to the school in its unopened, sealed package with the label affixed by the dispensing pharmacy intact.

(3) The statements required in subsection (2) of this section

shall be kept on file in the office of the school nurse or school administrator.

(4) The school district or the governing body of each private and parochial school or school district shall inform the parent or guardian of the student that the school and its employees and agents shall not incur any liability as a result of any injury sustained by the student from any reaction to any medication to treat a hypoglycemic episode or a seizure or its administration, unless the injury is the result of negligence or misconduct on behalf of the school or its employees. The parent or guardian of the student shall sign a written statement acknowledging that the school shall incur no liability except as provided in this subsection, and the parent or guardian shall hold harmless the school and its employees against any claims made for any reaction to any medication to treat a hypoglycemic episode or a seizure or its administration if the reaction is not due to negligence or misconduct on behalf of the school or its employees.

(5) The permission for the administration of either glucagon or diazepam rectal gel shall be effective for the school year in which it is granted and shall be renewed each following school year upon fulfilling the requirements of subsections (2) to (4) of this section.

(6) The school nurse or school administrator shall check the expiration date monthly for each emergency glucagon kit or diazepam rectal gel prefilled unit-dose delivery system in the possession of the school. At least one (1) month prior to the expiration date of each medication, the school nurse or school administrator shall inform the parent or guardian of the expiration date.

(7) The requirements of subsections (1) to (6) of this section shall apply only to schools that have a student enrolled who:

(a) Has a seizure disorder and has diazepam rectal gel in a prefilled unit-dose delivery system prescribed by the student's health care provider; or

(b) Has diabetes mellitus and has a glucagon emergency kit prescribed by the student's health care provider.

(8) Nothing in this section shall be construed to require a school employee to consent to administer glucagon or diazepam rectal gel to a student if the employee does not otherwise consent to provide the health service under KRS 156.502."

The American Diabetes Association and Kentucky diabetes advocates worked to improve the wording of the original bill and also worked for its passage. The original bill passed the Senate but died in committee in the House. However, due to the pressure brought to bear and the hard work and leadership of Senator Denton, the guts of the original bill were added to another bill (HB 88) in free conference committee. This time the bill passed both the House and the Senate!

There were many legislators, volunteers and our state ADA lobbyist, Bob Babbage, who worked hard on this issue. This is a big victory for children who have diabetes in KY schools! ***Thanks again to the many KY legislators that helped make this bill become law --- in particular Senator Denton, Rep . Bob Damron, House Majority Caucus Chair, and Rep. Susan Westrom sponsor of HB 88.***

For a copy of this law, visit
http://www.lrc.ky.gov/record/05rs/HB88.htm .

Notes To DIABETES EDUCATORS

With the passage of House Bill 88, KY diabetes educators may need to become prepared to assist KY school personnel to learn proper procedures for glucagon administration.

School requests for this training will likely take place as the new 2005-06 school year begins.

USING INSULIN ANALOGS TO THEIR FULL POTENTIAL

Nancy Tarr Anderson, M Ed, RN, RD, LD, CDE
DECA Member
Program Coordinator for Patient First Physician Group

Rapid-acting insulin like Humalog and Novolog have been available for quite some time but there still seems to be hesitancy on the physicians' part to use them. I believe that this hesitancy results from several factors including: fear of hypoglycemia; an assumption that the patient will not take multiple injections; and underestimating the patient's ability to learn how to titrate an insulin dose for optimal blood glucose control.

The case for using these analogs (Humalog and Novolog) along with a once-daily basal injection (Lantus) in a multiple daily injection regimen (MDI) is a strong one. If presented in a simple, easy to follow format, the patient's risk for hypoglycemia is actually reduced compared to other insulin regimens.

Mixed insulin prescribed twice daily is commonly the approach taken when patients need meal-time insulin. Two injections daily initially sounds more appealing than MDI and is acceptable if optimal blood glucose control can be achieved. However, drawbacks include an increased risk of hypoglycemia because of the unpredictability of the basal insulin. This can be minimized to some extent if the patient is willing to take the injections at the same time each day and keep the amount of physical activity consistent. The other challenge with this type of regimen is that it confines the patient to an inflexible meal plan where the timing and amount of carbohydrates consumed should not be varied. Patients who have very consistent, predictable lifestyles and are willing to follow a calculated meal plan can do well on this type of regimen.

When patients understand that MDI therapy will enable them to have flexible lifestyles and allow varied meal times, it becomes a much easier "sell". The only factor in this therapy that must be done at the same time each day is the basal injection. For most patients, this is bedtime. **I have found that when patients understand the pros and cons of each therapy, most opt for the treatment which poses the least restriction and affords the most flexibility. It is very much about the approach the practitioner takes. What a disservice we do to our patients when all we ask is," Would you rather be on 2 or 4 shots?"**

Insulin pens are available now for basal insulin (Lantus) as well as the insulin analogs. The pens simplify the task of dosing insulin, minimize error, and are convenient. Many patients feel less intimidated by the pens and therefore feel more confident. I have had patients tell me that they hardly consider a pen injection a "shot" because the standard syringe is not used. Once the patient feels confident, the anxiety minimizes and learning can occur.

Next, the patient must know how to count carbohydrates. I use the food pyramid and draw big STARS near each of the carbohydrate categories. I have the patient visualize a snack-pack pudding cup (about ½ cup) and tell them that each serving of carbohydrate is approximately equivalent in size to the "snack pack pudding cup" (and this equals one STAR). Most patients can tell you that a baked potato is a carbohydrate but do not know how many grams of carbohydrate it contains. I ask them, "How many times would your baked potato fit into that imaginary pudding cup?" If the answer is twice, that's 2 carbohydrate STARS. A potato that fits three times equals 3 carbohydrate STARS, and so on.

For patients who need to lose weight, make a recommendation for a maximum STAR intake per day. (Teach fat reduction at another session to avoid information overload). Stress that fewer STARS mean less insulin, which will help tremendously with weight control. This is one of the benefits of MDI as compared to standard insulin dosing. Patients are much less likely to have to "eat to keep up with their insulin" because they are only taking the insulin they need at that given time. At the initial teaching session, have the patient write out a sample meal, including portion size and count the STARS comprised in that meal. This is a great way to assess understanding.

Next, for those patients who use packaged foods, teach them how to read the food label, with emphasis on serving size and TOTAL CARBOHYDRATES. Each 15 grams of carbohydrate equals one carbohydrate STAR. For patients who are math-challenged, make a simple cheat sheet.

Once this is mastered, a patient can be given a carbohydrate to insulin ratio, as prescribed. Many patients start with one unit of insulin analog per carbohydrate "STAR". Larger people may need to start with 2 or even 3 units per "STAR".

It is always best to start conservatively and assure the patient that you will help them make adjustments along the way. Stress that adjustments are made based on the home blood glucose levels, which are to be recorded 4 times daily. As long as the patient knows that this is a process that takes a little time, discouragement and doubt can be avoided.

A correction scale should be given by calculating insulin sensitivity. This is determined by doubling the basal dose (Lantus) and dividing into 1500. For example, if a person takes 25 units of Lantus, simply divide 50 (25x2) into 1500, which equals 30. A correction scale would be as follows:
If before meal blood glucose is:

90-120: Take meal dose as determined above
121-150: Add 1 unit to meal dose
151-180: Add 2 units to meal dose
181-210: Add 3 units to meal dose
…And so on.

Stress that there are two parts to the equation: A before meal blood glucose AND a carbohydrate amount. The proper insulin dose cannot be determined if a piece of the equation is missing. The patient can be taught to take 25% less insulin if extra activity is planned after a particular meal just as extra insulin can be added for meals that have been known to spike blood glucose levels.

Make charts for your patients and ask them to keep records for the first week or two. With proper education and support, most patients can succeed. And perhaps most importantly, they will be reducing their risk of complications. Many patients have expressed that this type of insulin therapy makes sense to them and wonder why they were not introduced to it sooner!

ANTIBODY BLOCKS RETINOPATHY IN MICE

Submitted by: Twynette Davidson
Executive Director, JDRF Kentuckiana Chapter

A new discovery could help millions of people with diabetes avoid the complication of retinopathy, which is the leading cause of adult blindness in Americans and has no cure. The breakthrough emerged from a study in which JDRF-funded scientists at the University of Florida found that they could prevent retinopathy in lab mice by injecting an antibody into the eye to block the action of a protein called SDF-1.

The study was the first to present a solid link between SDF-1 (which stands for stromal cell-derived factor-1) and diabetic retinopathy, characterized by rampant growth of blood vessels in the retina. The finding offers researchers an attractive strategy for developing drugs to slow or prevent the complication. The antibody will be tested in monkeys in a study beginning next month, and, if successful, will proceed to human clinical trials.

"We're encouraged by the discovery of a new target for therapeutics for diabetic retinopathy," says Richard Insel, M.D., JDRF's Executive Vice President for Research. "These new insights can be quickly exploited to translate the discovery to therapeutics that can be evaluated in human type 1 diabetes. If successful, a therapeutic for retinopathy could benefit all patients with diabetes, not just those with type 1 diabetes."

Diabetic retinopathy is the most common eye condition related to diabetes, and the most serious. The early stage of the disease, known as "background" diabetic retinopathy, unfolds as the walls of the retina weaken from high blood sugar and high blood pressure, developing small, dot-like bulges, or "micro-aneurysms," which can leak fluid or blood into the surrounding tissue. Researchers are uncertain of the mechanism causing this deterioration.

In the second, more destructive stage, called proliferative diabetic retinopathy, new blood vessels form on the retina in response to the damage. Growth factors such as SDF-1 draw cells that specialize in repair to the site of injury. (These cells, called bone-marrow-derived precursor cells, originate in the bone marrow and circulate in the blood.) When called to the spot where damage occurred, the cells generate new blood vessels as part of the repair.

The new vessels, however, tend to be fragile and break easily, allowing blood to leak into the retina and the clear gel-like vitreous that fills the inside of the eye. Unless quickly treated, this leakage can cause scar tissue to form and further detach the retina, leading to vision loss and temporary or permanent blindness.

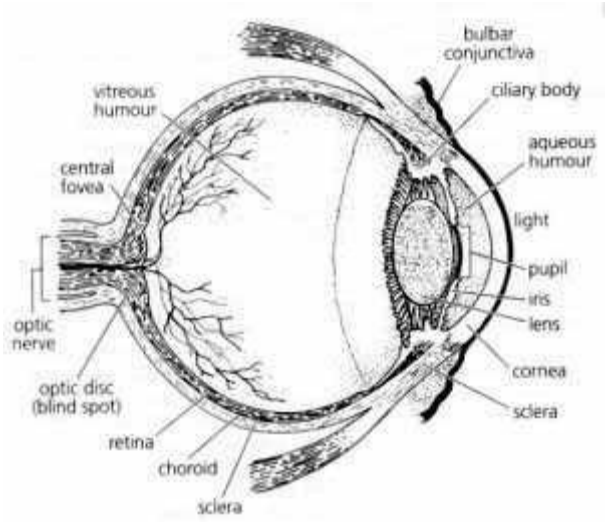
The new study provides evidence that SDF-1 contributes to this aberrant blood vessel growth, and thus, may play a major role in human diabetic retinopathy. Normally, SDF-1 spurs the blood vessel growth and then dissipates when repair is complete. However, after leaking from the fragile blood vessels into the vitreous, the SDF-1 becomes too concentrated, causing more and more aberrant blood vessels to form.

The researchers, led by Edward Scott, Ph.D., suspected SDF-1 might be contributing to retinopathy after they detected higher levels of the protein in the eyes of patients with diabetes compared with the eyes of nondiabetic patients. This hypothesis was confirmed when they demonstrated the link between SDF-1 and retinopathy by giving the protein to mice and creating retinopathy-like conditions. The researchers then injected into the animals' affected eyes an antibody to block SDF-1, effectively halting the growth of new blood vessels. The findings, reported in the January 2005 issue of the Journal of Clinical Investigation, suggest that antibodies blocking SDF-1 could be an effective and safe therapy against diabetic retinopathy.

"The scientific community and pharmaceutical companies have a long track record of being able to develop antibody-based therapy in things like snake anti-venoms," Scott said. "This isn't a new and unproven technology. This is something that can be rapidly adapted and brought to market."

If the antibody proves safe and effective in humans, the researchers envision a therapy involving routine injections of the substance into a patient's eyes. Current therapy for advanced diabetic retinopathy uses a laser beam to seal the leaks in the eye and prevent new blood vessels. However, this treatment destroys part of the retina in the process. A drug blocking SDF-1 would offer a less destructive method for treating the complication.

The research was conducted as part of the JDRF Center for Gene Therapy for the Prevention of Diabetes and its Complications at the University of Florida and the University of Miami.



Sign Up To Be A Diabetes Advocate Through the American Diabetes Association

Sign up to receive Diabetes Advocacy Alerts through the American Diabetes Association via www.diabetes.org, Go to Advocacy and Legal Resources, then Advocacy Action Center.

Walk for Diabetes to be Held in Lexington-- June 4, 2005

Stewart Perry, Chair National American Diabetes Association, Advocacy Committee

More than 18 million Americans have diabetes today—and a third of them don't even know it. Lexington, Kentucky is working to make a difference by joining thousands of walkers around the nation who are participating in the America's Walk for Diabetes.

Walking can help reduce the risk of developing type 2 diabetes and raise money in the fight against diabetes. For more information regarding how to join the diabetes walkers in Lexington on June 4, 2005, contact Lisa Edwards at 859-268-9129 or ledwards@diabetes.org or online at walk.diabetes.org or call the American Diabetes Association 1-888-DIABETES (342-2383).

Free Equipment Offered for In–Office Diabetes Management

Ann Hinson, National Regulatory Affairs and Special Project Manager, FDI Medical

FDI Medical, a distributor of medical diagnostic equipment and products, is offering FREE medical equipment to enable health care facilities to diagnose, treat, and monitor patients with diabetes and cardiovascular disease.

The Bayer DCA 2000+ Analyzer (measures A1c and microalbuminuria) and the Cholestech LDX System (measures lipids, ALT, and AST) are being offered free to clinics and physician offices. The following is a description of the programs.

Bayer DCA 2000+ Program Description

- **Bayer DCA 2000+ Analyzer provided FREE**
- Initially, purchase a minimum of four boxes of A1c cartridges. Each box contains ten cartridges (forty tests).
- Monthly purchase at least four boxes of cartridges
- Receive customized Policy and Procedure Manuals and QC Logs for your facility
- Receive Free Staff Training
- Receive FDI Medical Program Specialist support in meeting Federal and State regulatory compliance
- FDI Medical Program Specialist will also assist your facility in achieving optimum reimbursement

Cholestech LDX Program Description

- **Cholestech LDX System provided FREE**
- Initially, purchase four boxes of Lipid or Lipid plus Glucose Cassettes. Each box contains ten cassettes (forty tests).
- Monthly purchase at least four boxes of cartridges
- Receive customized Policy and Procedure Manuals and QC Logs
- Receive Free Staff Training
- Receive FDI Medical Program Specialist support in meeting Federal and State regulatory compliance
- FDI Medical Program Specialist will also assist your facility in achieving optimum reimbursement

Program Benefits

- Test results in five minutes from a fingerstick
- Immediate face to face consultation
- Increased patient compliance
- Reimbursement from Medicare, Medicaid, and most private pay insurance providers
- One source and contact person
- CLIA – waived

If you currently have a Bayer DCA 2000+ or a Cholestech LDX Analyzer, you still qualify for the Specialized Programs. Speak to your FDI Medical Program Specialist for specific details.

FDI Medical Program Specialist Contact Information

- Ann Hinson
  888 – 300 – 6057 ext 29
  ahinson@fdimedical.com

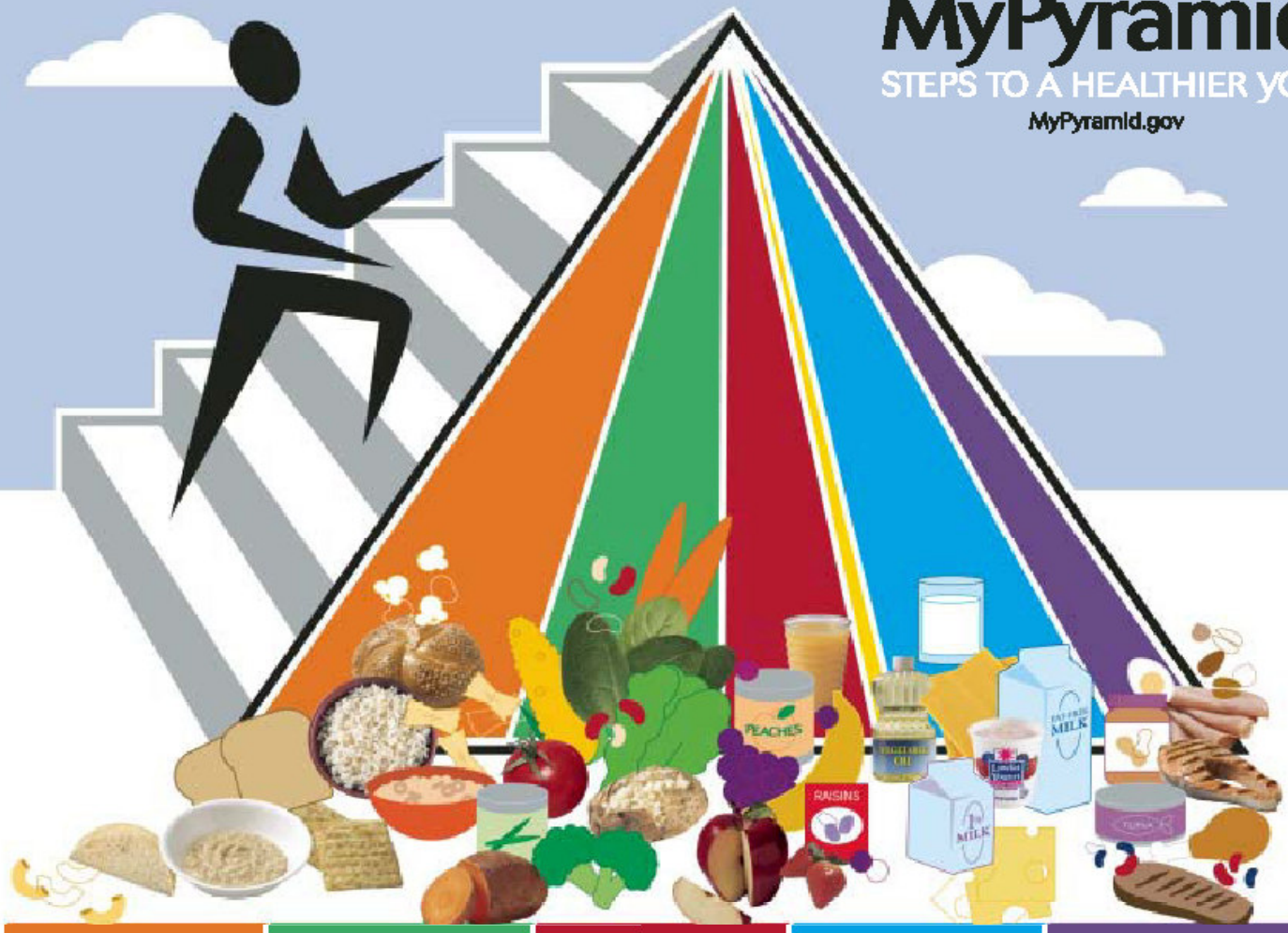
- Tony Penta
  888 – 300 – 6057 ext 20
  tpenta@fdimedical.com

  FDI Medical • 17 South Avenue • Natick, MA 01760
  www.fdimedical.com

MyPyramid

STEPS TO A HEALTHIER YOU

MyPyramid.gov



GRAINS Make half your grains whole	VEGETABLES Vary your veggies	FRUITS Focus on fruits	MILK Get your calcium-rich foods	MEAT & BEANS Go lean with protein
Eat at least 3 oz. of whole-grain cereals, breads, crackers, rice, or pasta every day 1 oz. is about 1 slice of bread, about 1 cup of breakfast cereal, or ½ cup of cooked rice, cereal, or pasta	Eat more dark-green veggies like broccoli, spinach, and other dark leafy greens Eat more orange vegetables like carrots and sweetpotatoes Eat more dry beans and peas like pinto beans, kidney beans, and lentils	Eat a variety of fruit Choose fresh, frozen, canned, or dried fruit Go easy on fruit juices	Go low-fat or fat-free when you choose milk, yogurt, and other milk products If you don't or can't consume milk, choose lactose-free products or other calcium sources such as fortified foods and beverages	Choose low-fat or lean meats and poultry Bake it, broil it, or grill it Vary your protein routine — choose more fish, beans, peas, nuts, and seeds
Eat 6 oz. every day	Eat 2½ cups every day	Eat 2 cups every day	Get 3 cups every day; for kids aged 2 to 8, it's 2	Eat 5½ oz. every day

For a 2,000-calorie diet, you need the amounts below from each food group. To find the amounts that are right for you, go to MyPyramid.gov.

Find your balance between food and physical activity

- Be sure to stay within your daily calorie needs.
- Be physically active for at least 30 minutes most days of the week.
- About 60 minutes a day of physical activity may be needed to prevent weight gain.
- For sustaining weight loss, at least 60 to 90 minutes a day of physical activity may be required.
- Children and teenagers should be physically active for 60 minutes every day, or most days.

Know the limits on fats, sugars, and salt (sodium)

- Make most of your fat sources from fish, nuts, and vegetable oils.
- Limit solid fats like butter, margarine, shortening, and lard, as well as foods that contain these.
- Check the Nutrition Facts label to keep saturated fats, *trans* fats, and sodium low.
- Choose food and beverages low in added sugars. Added sugars contribute calories with few, if any, nutrients.

MyPyramid.gov
STEPS TO A HEALTHIER YOU

U.S. Department of Agriculture
Center for Nutrition Policy and Promotion
April 2005
CNPP-15

USDA

2005 DIETARY GUIDELINES RELEASED

The *Dietary Guidelines for Americans 2005*, the federal government's science-based advice to promote health and reduce risk of chronic diseases through nutrition and physical activity was recently released.

The sixth edition of *Dietary Guidelines for Americans* places stronger emphasis on reducing calorie consumption and increasing physical activity. This joint project of the Departments of Health and Human Services and Agriculture is the latest of the five-year reviews required by federal law. The report identifies 41 key recommendations, of which 23 are for the general public and 18 are for special populations. They are grouped into nine general topics:

- Adequate Nutrients Within Calorie Needs
- Weight Management
- Physical Activity
- Food Groups to Encourage
- Fats
- Carbohydrates
- Sodium and Potassium
- Alcoholic Beverages
- Food Safety

The 2005 Dietary Guidelines and consumer brochure are available at www.healthierus.gov/dietaryguidelines.

Following is a list of key recommendations from the Dietary Guidelines.

2005 DIETARY GUIDELINES FOR AMERICANS

Key Recommendations for the General Population

ADEQUATE NUTRIENTS WITHIN CALORIE NEEDS

- Consume a variety of nutrient-dense foods and beverages within and among the basic food groups while choosing foods that limit the intake of saturated and trans fats, cholesterol, added sugars, salt, and alcohol.
- Meet recommended intakes within energy needs by adopting a balanced eating pattern, such as the U.S. Department of Agriculture (USDA) Food Guide or the Dietary Approaches to Stop Hypertension (DASH) Eating Plan.

WEIGHT MANAGEMENT

- To maintain body weight in a healthy range, balance calories from foods and beverages with calories expended.
- To prevent gradual weight gain over time, make small decreases in food and beverage calories and increase physical activity.

PHYSICAL ACTIVITY

- Engage in regular physical activity and reduce sedentary activities to promote health, psychological well-being, and a healthy body weight.
- To reduce the risk of chronic disease in adulthood: Engage in at least 30 minutes of moderate-intensity physical activity, above usual activity, at work or home on most days of the week.
- For most people, greater health benefits can be obtained by engaging in physical activity of more vigorous intensity or longer duration.
- To help manage body weight and prevent gradual, unhealthy body weight gain in adulthood: Engage in approximately 60 minutes of moderate- to vigorous-intensity activity on most days of the week while not exceeding caloric intake requirements.
- To sustain weight loss in adulthood: Participate in at least 60 to 90 minutes of daily moderate-intensity physical activity while not exceeding caloric intake requirements. Some people may need to consult with a healthcare provider before participating in this level of activity.
- Achieve physical fitness by including cardiovascular conditioning, stretching exercises for flexibility, and resistance exercises or calisthenics for muscle strength and endurance.

FOOD GROUPS

- Consume a sufficient amount of fruits and vegetables while staying within energy needs. Two cups of fruit and 2½ cups of vegetables per day are recommended for a reference 2,000-calorie intake, with higher or lower amounts depending on the calorie level.
- Choose a variety of fruits and vegetables each day. In particular, select from all five vegetable subgroups (dark green, orange, legumes, starchy vegetables, and other vegetables) several times a week.
- Consume 3 or more ounce-equivalents of whole-grain products per day, with the rest of the recommended grains coming from enriched or whole-grain products. In general, at least half the grains should come from whole grains.
- Consume 3 cups per day of fat-free or low-fat milk or equivalent milk products.

FATS

- Consume less than 10 percent of calories from saturated fatty acids and less than 300 mg/day of cholesterol, and keep trans fatty acid consumption as low as possible.
- Keep total fat intake between 20 to 35 percent of calories, with most fats coming from sources of polyunsaturated and monounsaturated fatty acids, such as fish, nuts, and vegetable oils.

- When selecting and preparing meat, poultry, dry beans, and milk or milk products, make choices that are lean, low-fat, or fat-free.
- Limit intake of fats and oils high in saturated and/or trans fatty acids, and choose products low in such fats and oils.

CARBOHYDRATES

- Choose fiber-rich fruits, vegetables, and whole grains often.
- Choose and prepare foods and beverages with little added sugars or caloric sweeteners, such as amounts suggested by the USDA Food Guide and the DASH Eating Plan.
- Reduce the incidence of dental caries by practicing good oral hygiene and consuming sugar- and starch-containing foods and beverages less frequently.

SODIUM AND POTASSIUM

- Consume less than 2,300 mg (approximately 1 teaspoon of salt) of sodium per day.
- Choose and prepare foods with little salt. At the same time, consume potassium-rich foods, such as fruits and vegetables.

ALCOHOLIC BEVERAGES

- Those who choose to drink alcoholic beverages should do so sensibly and in moderation-defined as the consumption of up to one drink per day for women and up to two drinks per day for men.
- Alcoholic beverages should not be consumed by some individuals, including those who cannot restrict their alcohol intake, women of childbearing age who may become pregnant, pregnant and lactating women, children and adolescents, individuals taking medications that can interact with alcohol, and those with specific medical conditions.
- Alcoholic beverages should be avoided by individuals engaging in activities that require attention, skill, or coordination, such as driving or operating machinery.

FOOD SAFETY

- To avoid microbial foodborne illness:
- Clean hands, food contact surfaces, and fruits and vegetables. Meat and poultry should not be washed or rinsed.
- Separate raw, cooked, and ready-to-eat foods while shopping, preparing, or storing foods.
- Cook foods to a safe temperature to kill microorganisms.
- Chill (refrigerate) perishable food promptly and defrost foods properly.
- Avoid raw (unpasteurized) milk or any products made from unpasteurized milk, raw or partially cooked eggs or foods containing raw eggs, raw or undercooked meat and poultry, unpasteurized juices, and raw sprouts.

Note: The Dietary Guidelines for Americans 2005 contains additional recommendations for specific populations. The full document is available at www.healthierus.gov/dietaryguidelines.

NEW DIABETES CARE RESOURCE GUIDE OFFERS HELP TO STATES

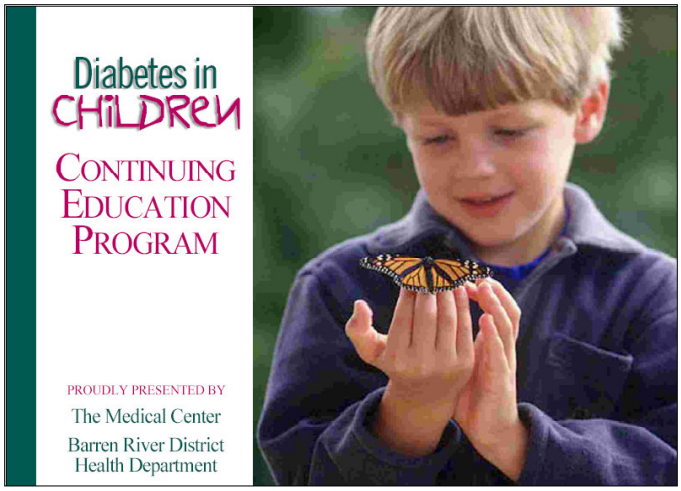
The Agency for Healthcare Research and Quality (AHRQ), in partnership with the Council of State Governments, recently released, *" Diabetes Care Quality Improvement: A Resource Guide for State Action"* and its companion workbook, both of which are designed to help states assess the quality of diabetes care and develop quality improvement strategies. The guide and workbook provide an overview of the factors that affect quality of care for diabetes, present the core elements of health care quality improvement, assist state policymakers in using the data from AHRQ's 2003 National Healthcare Quality Report for planning state-level quality improvement activities, and provide a variety of best practices and policy approaches that national organizations, the federal government, and states have implemented related to diabetes quality improvement. A print copy is available by sending an e-mail to ahrqpubs@ahrq.gov.

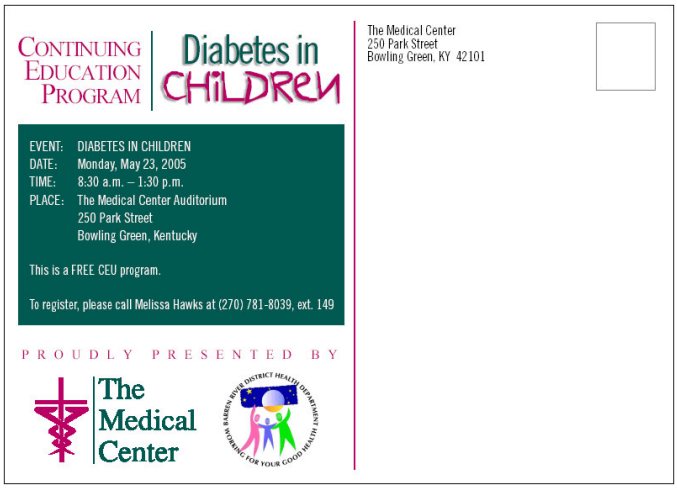
KENTUCKY DIABETES PREVENTION & CONTROL PROGRAM RELEASES NEW DIABETES BURDEN DOCUMENT

The Kentucky Diabetes Prevention & Control Program (KDPCP), through the Kentucky Department for Public Health, has published a new *Diabetes in Kentucky Burden Document.* This resource was last published several years ago and has been updated with the newest Kentucky diabetes surveillance data. To receive a FREE copy of this document, contact KDPCP at 502-564-7996, ask for the diabetes program, or email Reita Jones at reita.jones@ky.gov

FREE Diabetes in Children CEU Offered!

A **FREE** diabetes continuing education program (CEU) is being offered on Monday, May 23, from 8:30 AM to 1:30 PM in Bowling Green at the Medical Center Auditorium, 250 Park Street, Bowling Green, KY. The program, ***"Diabetes in Children"***, will feature speakers, Dr. Deanna Aftab Guy, Pediatric Endocrinologist from Vanderbilt, Diane Davidson, with Medtronic Mini Med, and Dr. Debra Sowell, Pediatritian. The program is offered **FREE** through the Medical Center and Barren River District Health Department Diabetes Programs. To register, call Melissa Hawks at 270-781-8039 ext. 149.





EPA Recommendations For Handling Sharps Changes

As the number of people taking medicines by injection has risen, so have concerns about the safe disposal of sharps (needles and lancets). According to the American Diabetes Association, Americans use and discard more than 3 billion sharps each year. In the past, the Environmental Protection Agency (EPA) recommended putting sharps in the regular trash in some sort of hard container (like a detergent bottle). However, recently the EPA updated its recommendations to decrease needle stick injuries among the public.

The EPA, working with a national advocacy group called the Coalition for Safe Community Needle Disposal, revised its recommendations for sharps disposal. For a copy of the new EPA recommendations, visit www.epa.gov/epaoswer/other/medical/sharps.htm. To learn about laws in Kentucky relating to syringe disposal, visit www.cdc.gov/needledisposal/. To find out about disposal options in your area, contact the Coalition for Safe Community Needle Disposal at 1-800-643-1643 or www.safeneedledisposal.org/dispcenters.php.

New Kentucky Sharps Disposal Fact Sheet Developed --- Use for Patient Education

Upon receiving the new Environmental Protection Agency (EPA) guidelines regarding sharps disposal, Theresa Renn and Janice Haile, state staff with the Kentucky Diabetes Prevention and Control Program (KDPCP), met with Kentucky Division of Waste Management (DWM) Staff, Cathy Guess and Sara Evans, to discuss the impact the new EPA guidelines might have on Kentucky.

As a result of this meeting, a new fact sheet (entire text printed within this newsletter) was developed to assist Kentucky citizens in the safe disposal of sharps. The fact sheet may be downloaded at www.waste.ky.gov and used by endocrinologists, diabetes educators, and other medical professionals to educate individuals with diabetes regarding sharps disposal in Kentucky.

The KY DWM also plans to work with KDPCP and others to further review the recommendations recently published by the U.S. Environmental Protection Agency and The Coalition for Safe Community Needle Disposal to explore other alternative methods of sharps disposal in Kentucky.

Kentucky Environmental & Public Protection Cabinet

Fact Sheet

Safe Options for Home Needle Disposal

In Kentucky, medical waste falls under the legal definition of municipal solid waste (household and commercial solid waste) and is therefore subject to the same legal requirements as household garbage. As such, it may legally be disposed of with the household garbage in a permitted contained landfill. However, medical waste can pose its own set of problems, especially for waste haulers who may inadvertently come in contact with needles or other medical waste that has not been properly managed. The Kentucky Division of Waste Management offers the following recommendations for safe disposal of sharps (needles, syringes, and lancets) used in the home:

- Use a sharps container purchased from a local pharmacy.
- Contact your local hauler to advise when you will set out the sharps container.
- If possible, set the sharps container out on the morning of pickup.
- Set the sharps container on top of bagged garbage; ensure that it is marked as a sharps container.
- Place a lid on the garbage can to prevent tampering.

Needle-stick injuries are a preventable health risk. Used sharps can injure people, spread germs, and spread diseases. The importance of using a purchased sharps container is to provide safe disposal of sharps in the home and to protect the collectors when they pick up the waste at the curbside. Do not dispose of sharps in the trash unless they are contained within a sharps container. Do not flush them down the toilet.

The U.S. Environmental Protection Agency recently placed "New Information About Disposing of Medical Sharps" on its main Medical Waste page at http://www.epa.gov/epaoswer/other/medical/ The Coalition for Safe Community Needle Disposal is working with EPA to evaluate and promote alternative disposal methods for used needles and other medical sharps. Publications with safety disposal tips for patients and healthcare professionals are online at http://www.epa.gov/epaoswer/other/medical/download.htm#general

Division of Waste Management

Governor Ernie Fletcher Secretary LaJuana S. Wilcher

14 Reilly Road, Frankfort KY 40601 Phone: (502) 564-6716 Fax: (502) 564-4049

Telecommunications device for the deaf/hard-of-hearing: (502) 564-0172

E-mail: waste@ky.gov Web site: http://www.waste.ky.gov/

March 2005

Kentucky UNBRIDLED SPIRIT

JDRF Offers FREE Program for Children Newly Diagnosed with Diabetes

Twynette Davidson
Executive Director, JDRF Kentuckiana Chapter

The Juvenile Diabetes Research Foundation (JDRF) offers a **free** public outreach program to support families with a child that has been newly diagnosed with diabetes. The program's goal is to deliver a care package of information to help families learn more about diabetes, diabetes research, and the management and control of this disease. Along with this valuable information about diabetes, JDRF also partners newly diagnosed families with another family who has been through the same experience.

What is the bag of hope?
The Bag of Hope is a free canvas tote bag filled with a comprehensive collection of educational, comfort, and support material for children ages newborn to 11 as well as materials for the adult caregiver. Included in the bag are items such as:

- Rufus (or Ruby) the Bear - a cuddly stuffed animal with diabetes!
- Accu-Chek Compact Blood Meter
- Carbohydrate Counter Slide Tool
- Diabetes books for kids and adults

… and much more.

What about older kids?
If a individual has a teenager (11-20) who has just been diagnosed with diabetes, JDRF has a special **"Teen Pak"** with educational contents similar to those in the child's bag, but also including a surf watch, key chain flashlight and a notepad.

How does the program work?
When a person contacts JDRF, their information will be given to a "Bag of Hope" volunteer in their area. This volunteer is a parent of a child with diabetes, and he or she will contact that person to set up a meeting to deliver the "Bag of Hope". Visits are scheduled at the mutual convenience of the volunteer and family. At the meeting, the volunteer will bring the Bag of Hope or Teen Pak and talk with the entire family, when possible. The volunteer can answer non-medical questions and share stories about personal experiences. Most importantly, they provide a valuable support system for the child with diabetes and their family. If there is not a volunteer in the area, JDRF will mail a Bag of Hope or Teen Pak and ask a volunteer to call.

How to request a BAG OF HOPE or TEEN PAK?
There are three ways to request a Bag of Hope or Teen Pak:

1. *Call JDRF* ***at (502) 485-9397 or (866) 485-9397.***
2. *E-mail* request to **Kentuckiana@jdrf.org.** Please include full name, mailing address, telephone number, name, age and sex of child, month and year of diagnosis.
3. *Return the form* at the right by mail or fax to JDRF office.

JDRF will connect the person with a parent volunteer as soon as possible!

Bag of Hope/Teen Pak Request Form
Parent's Name:_____
Address:_____
_____
Phone:_____
E-mail:_____
Best time to call:_____
Child's Name:_____
Child's Age:_____ Sex: ❑M ❑F
Month/Year of Diagnosis:_____

In addition to a Bag of Hope/Teen Pak, the person will automatically receive "*Kentuckiana Discoveries"*, a free quarterly newsletter that includes JDRF efforts to find a cure for diabetes. Other HOPE-filled news is available at **www.jdrf.org. www.jdrf.org/chapters/KY/Kentuckiana**

Mail completed form to:
Juvenile Diabetes Research Foundation International
Kentuckiana Chapter
133 Evergreen Rd., Suite 101
Louisville, KY 40243
Or fax to:
(502) 485-9591

Sign Up To Receive Advocacy Updates Through JDRF

If interested in diabetes advocacy, especially as it relates to "diabetes in children", visit www.jdrf.org , click on "Advocacy" and then click on "Register as Advocate". Once registered, diabetes alerts will be sent.

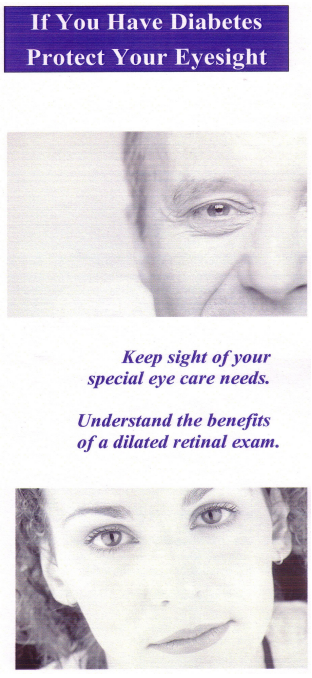
NEW DIABETES EYE BROCHURE DEVELOPED --- INCLUDES FORM FOR OBTAINING TEST RESULTS FROM EYE PROVIDERS

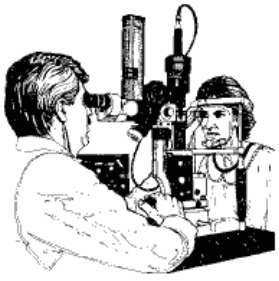
A new diabetes and eye disease brochure was recently developed by the Kentucky Diabetes Network's Health Plan Partners and is now available to download online. The difference in this brochure and other diabetes and eye disease brochures -- is that this new brochure **includes a form which can be completed by the eye care provider and returned to the primary medical provider and / or diabetes educator.**

According to Karen Wooldridge, Chair of the KDN Health Plan Partners, " HEDIS (see note) results for dilated eye exams were typically low when charts were reviewed in primary care providers offices." "It was felt that missing data was a major contributor to low dilated eye exam reports." "Thus members of the KDN Health Plan Partners developed this new brochure as an educational piece which includes a form which can be used by primary care providers, eye care providers, diabetes educators and individuals who have diabetes – to ensure that dilated eye exam results are returned to the primary care providers chart."

Numerous Health Care Plans across KY are planning to utilize this new brochure with distribution to their respective diabetes populations. In addition, the brochure is available to be downloaded and copied for use by any primary care provider, eye care provider, diabetes educator, or person with diabetes. The brochure can be downloaded at www.kentuckydiabetes.net .

Note: HEDIS data is a set of standardized performance measures, designed by the National Committee on Quality Assurance (NCQA), to ensure purchasers and consumers have information to reliably compare the performance of managed health care plans.





Below is a copy of the "Form" page that is part of the new diabetes and eye brochure (brochure is for use with diabetes patients):

HOW TO USE THIS FORM:

1. Fill out "Your Information" section
2. Ask your eye doctor to fill out the "Eye Care Office" section.
3. Detach the form at the dotted line, fold over and seal. Fill out the mailing label with your family doctor's address and your return address.
4. Mail or carry this form to your family doctor so it can be put in your medical chart.

Your Information

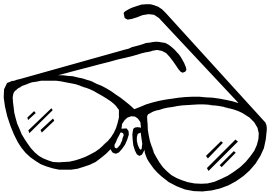
Name: _____***DOB***____
Address: _____
_____
_____

Family doctor's name/address:
_____
_____
_____

Eye care professional's name/office address:

Eye Care Office

Date of exam: _____
Check all that apply:
Non-proliferative retinopathy □ ***No*** □ ***Yes***
Proliferative retinopathy □ ***No*** □ ***Yes***
Cataracts □ ***No*** □ ***Yes***
Glaucoma □ ***No*** □ ***Yes***
□ ***Other*** _____
Visual Acuity _____
Next recommended visit: _____
Eye care professional's signature:
_____



FDA Stops Distribution of Avandamet

The following is an excerpt from the U.S. Food and Drug Administration (FDA) website regarding the distribution of Avandament and Paxil CR

1. What are these drugs and what are they used to treat?

Avandamet is a combination product containing 2 drugs (rosiglitazone maleate and metformin hydrochloride) for the treatment of type 2 diabetes mellitus.
Paxil CR is a controlled release medication for the treatment of major depressive disorder and panic disorder.

2. What action did the FDA take?

The FDA and the Department of Justice have filed three actions in federal court to seize the remaining stocks of Avandamet and Paxil CR in three locations. The seizures are meant to prevent further distribution of the products.

3. Why did FDA take this action?

The FDA inspections of the facility that manufactures Avandamet and Paxil CR revealed deficiencies in the process controls in place to help assure manufacturing conditions and practices result in a high quality product. These violations have not been adequately corrected by the firm and could result in production of poor quality drug products that potentially could pose risks to consumers.

4. What were the manufacturing problems that resulted in FDA's seizure action?

The FDA inspections revealed that some lots of Avandamet tablets were not always manufactured uniformly and that these tablets may not have an accurate dose of rosiglitazone (one of the two active ingredients in Avandamet). The FDA also found that some lots of Paxil CR tablets were not manufactured properly and can split apart, so that patients may receive a portion of the tablets that lack any active ingredient or a portion that contains the active ingredient and does not have the intended controlled-release effect.

5. What impact will FDA's seizure of these drugs have on their supply?

The seizure of Avandamet and Paxil CR could result in a lack of availability of both drugs until the company is able to correct the manufacturing problems that necessitated the seizure. The FDA has determined that there are other products to treat the diseases for which these two products are used. Approved versions of the individual components of Avandamet (i.e., rosiglitazone and metformin) are available in the same doses as those found in the combination Avandamet tablets subject to seizure, with the exception of the 1 mg dose of rosiglitazone. Approved versions of the immediate release form of Paxil are also available.

6. When will these drugs be available again?

The FDA will attempt to ensure that the manufacturer corrects the manufacturing deficiencies as soon as possible so that production of new product that meets our public health high quality standards can occur.

7. What does the seizure of these drugs mean for patients? What should patients do?

Patients taking either of these drugs should continue taking their Avandamet and/or Paxil CR tablets and should talk to their health care provider about alternative forms of rosiglitazone (Avandia), metformin and/or Paxil or alternative products that could be taken until the manufacturing problems with these drugs have been corrected.

8. Does either of these products pose a risk to consumers taking them?

FDA does not believe that the products subject to this seizure pose a significant health hazard to consumers.
FDA is concerned that the extent of the manufacturing problems noted at the Cidra GSK facility could adversely affect the quality of these drug products, resulting in potential risk to consumers.

9. What doses of each drug are affected?

The following doses of Avandamet and Paxil CR tablets are subject to the seizure:

- Avandamet 1 mg/500mg
- Avandamet 2 mg/500 mg
- Avandamet 2 mg/1,000 mg
- Avandamet 4 mg/500 mg
- Avandamet 4 mg/1,000 mg
- Paxil CR 12.5 mg, 25 mg and 37.5 mg tablets

10. Is the immediate release form of Paxil subject to the seizure?

No, 10 mg, 20 mg, 30 mg, 40 mg of the immediate release form of Paxil are approved and not subject to these seizures. Patients can take these with confidence.

Production Stopped

Summer Diabetes Camp Guide For Children With Diabetes in Kentucky And Surrounding States

Kentucky

Camp Hendon

American Diabetes Association residential camp located at Camp Crooked Creek in Shepherdsville, KY.

Camp Dates: July 24 - 30
Camper Ages: 8-17
Camp Fees: $300 - ADA Members
$325 - Non Members
$565 for 2 children of ADA Members
$625 – for 2 children of Non Members
Contact: Laura Hines at 888-342-2383 x-3324
Nurses and Dietitians are needed to work at the Kentucky camp. Contact Laura Hines. (see above for information)

Illinois

Camp Granada

American Diabetes Association resident camp located in Monticello, Illinois at the 4H Memorial Camp owned by the University of Illinois.

Camp Dates: July 17-22, 2005
Camper Ages: 8 through 16
Camp Fee: $400
Contact: Donna Scott at 217-875-9011, x-6641

Indiana

The Diabetes Youth Foundation Camp

Contact Dave Dozier, 317-247-4002 - www.dyfoindiana.org
Residential Camp
Session I - June 12-18
Session II - June 19-July 2

Camp John Warvel

American Diabetes Association resident camp held at the YMCA Camp Crosley in North Webster Camp is offered for children ages 7 through 15.
Camp Dates**:** June 5-11
Camp Fee**:** $225
Contact: Elaine McClane - in-state call 800-228-2897, out-of-state 317-352-9226.

Missouri

Camp Day Break

Camp Day Break is organized and operated by the Diabetes Center at Southeast Missouri Hospital in Cape Girardeau, Missouri. This day camp program is held at the Main Street Family Fitness Center in Jackson, Missouri. The camp provides a learning experience in the art of living with diabetes in the company of other children who face similar challenges each day. A day at Camp Day Break includes crafts, indoor and outdoor group games and diabetes education. Camper Ages: 6-12 Contact**:** Southeast Missouri Hospital at 573-651-5844 .

Ohio

Camp Korelitz

American Diabetes Association Camp Korelitz, is a residential camp held at YMCA Camp Campbell Gard in Hamilton, Ohio. During the week, campers will participate in group and individual activities including team sports, swimming, camp fires, outdoor education, arts and crafts, drama and archery.

Camp Dates: August 7-13
Camper Ages: 9-15
Camp Fees: $400 ADA Members; $450 NonMembers
Contact: Missy Jardine at 513-759-9330, x-6662 or 1-888-342-2383, x-6662

Camp Tokumto

American Diabetes Association Camp Tokumto is a day camp located in Sharon Woods in Cincinnati. Camp activities include arts and crafts, diabetes and diet education, field trips, swimming, and more.

Camp Dates: July 11 - 15
Camper Ages: 5-9
Camp Fees: $155 ADA Members; $180 Non Members
Contact: Missy Jardine at 513-759-9330, x-6662 or 1-888-342-2383, x-6662

Tennessee

Camp Sugar Falls

A summer day camp for kids ages 6-12. with diabetes will be held in Tennessee. The American Diabetes Association's Camp Sugar Falls will take place August 1 to 4, 2005 at Pleasant Green Swim Club in Goodlettsville, Tennessee, just north of Nashville. The fee is $55 per person, and takes place 10 a.m. - 3 p.m. For information about the camp, contact Lauren Kennedy at 615-298-3066, ext. 3333 or 1-888-342-2383, ext. 3333.

DECA Diabetes Educator Meetings Scheduled

Diabetes Educators of the Cincinnati Area (DECA), which covers Northern KY, meet the third Monday of each month (September through April) from 5:30 – 7:30 pm. Meetings are usually held at Good Samaritan Hospital in Cincinnati, Ohio; however location may vary. Anyone interested in diabetes is invited. Please register with Mary Ann Benzing 513-248-9992.

GLADE Diabetes Educator Meetings Scheduled

The Greater Louisville Association of Diabetes Educators (GLADE), which covers Louisville and the surrounding area, meets the 2nd Tuesday of the month from 5:30 – 7:30 pm *(no meeting in July or August).* There is no cost unless CEU's are provided. If continuing education is provided, the cost will be $5.00 for non-GLADE members. For a schedule or more information, contact GLADE President, Kim Jackson at 502-574-6663 or kimberly.jackson@loukymetro.org

KADE Diabetes Educator Meetings Scheduled

The Kentucky Association of Diabetes Educators (KADE), which covers Lexington and Central Kentucky, meets the 3rd Tuesday of every month except summer (time & location vary). For a schedule or more information, contact:
Karen McKnight
Phone: 859-313-4282
E-mail: mcknighk@chimail.sjhlex.org
or
Laura Hieronymus
Phone: 859-223-4074
laurahieronymus@cs.com

Next meeting: May 17, at 6 pm, Location to be Announced, Topic: Ketone Testing presented by Furesh Rao, MD. No KADE meetings are scheduled for June, July, or August.

Endocrinologists Meetings Scheduled

The Ohio Valley Chapter of the American Association of Clinical Endocrinologists (AACE) and the Kentuckiana Endocrine Club meet on a regular basis. For a schedule of meetings, contact:

Dr. Vasti Broadstone
Phone: 812-949-5700
E-mail: joslin@FMHHS.com

Kentucky Diabetes Network (KDN) Meetings Scheduled

The Kentucky Diabetes Network (KDN) is a network of public and private providers striving to improve the treatment and outcomes for Kentuckians with diabetes, to promote early diagnosis, and ultimately to prevent the onset of diabetes.

Quarterly general meetings are held from 10-3 pm EST. Anyone interested in improving diabetes outcomes in KY may join. A membership form may be obtained at www.kentuckydiabetes.net or by calling 502-564-7996 (ask for diabetes program).

Friday June 10	To Be Announced
Friday September 16	KY History Center (Frankfort)
Friday November 4	Baptist East Hospital (Louisville)

TRADE Diabetes Educator Meetings Scheduled

The Tri-State Association of Diabetes Educators (TRADE), which covers Western KY/Southern IN, meets quarterly from 11 – 2 pm CST with complimentary lunch and continuing education units. The planned meetings include:

Date: **Thursday, July 21, 2005**
Title: *TBA*
Speaker: Vasdev Lahano, MD, FACE
Location: Salem United Church of Christ
202 East Fourth Street
Huntingburg, IN

TRADE Workshop (in lieu of an October 20th seminar to be conducted jointly by KY diabetes educator chapters, KDN, KDPCP, ADA, JDRF, and endocrinologists – TRADE will not conduct their usual all day diabetes CEU. Instead a half day program is planned – see below).

Date: Friday, September 30, 2005
Time: *TBA*
Title: *TBA*
Speaker: Jane Bridges, MD
Location: Trover Clinic
8th Floor Conference Room
200 Clinic Drive
Madisonville, KY

DIABETES CARE TOOL

KENTUCKY DIABETES NETWORK, INC.

A statewide partnership striving to improve the treatment and outcomes for Kentuckians with diabetes.

Patient Name: _____ **DOB:** _____

Height: _____ **Smoker: Yes No** (circle one) **Pneumococcal Vaccine Date(s):** ____

Type of Diabetes: 1 2 (circle one) **Year of Diabetes Diagnosis:** _____

*This tool is based on the 2004 American Diabetes Association's "Standards of Medical Care for Patients with Diabetes Mellitus" and indicates minimum services to be provided in the continuing (initial visits have additional components) care of **adults** with diabetes. It is not intended to replace or preclude clinical judgement or more intensive management where medically indicated. Use it as a reminder for exams or important tests, to simplify record keeping and as a way to continually improve care to all patients with diabetes.*

Enter result, checkmark, or date as you deem appropriate.

	DATE OF VISIT						
EVERY VISIT	**Weight**						
	B/P (Goal <130/80)						
	A1C Hemoglobin A1c every 3–6 mo. (Goal <7%)						
	Foot Exam: • **Visual**						
ANNUAL	**Foot Exam:** • **Sensation, foot structure/biomechanics, vascular, and skin integrity**						
	Fasting Lipid Profile: • **Total Cholesterol** (Goal < 200)						
	• **LDL** (Goal < 100)						
	• **HDL** (Goal Men > 40, Women > 50)						
	• **Triglycerides** (Goal < 150)						
	Microalbumin Unless Urine dipstick positive for protein						
	Dilated Eye Exam/ Referral Date						
	Flu Vaccine						
	Oral Visualization						
COUNSELING	**Self-Management Education/ Referral Date**						
	Exercise /Physical Activity						
	Medical Nutrition Therapy Referral						
	Tobacco Cessation						
	Preconception Counseling (women of childbearing age)						
OTHER	**Review Self-Monitoring Blood Glucose Log**						
	Assess Need for Aspirin Therapy						

01-2004

Kentucky Diabetes Connection

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P.O. Box 309
Owensboro, KY 42302-0309

The Kentucky Diabetes Network (KDN) Paid Printing and Mailing Costs for this Newsletter

Contact Information

American Diabetes Association.
Cure • Care • Commitment®
www.diabetes.org
1-888-DIABETES

TRADE
Tri-State Association of Diabetes Educators
www.aadenet.org/AboutAADE/Chapters.html

KDN
KENTUCKY DIABETES NETWORK, INC.
www.kentuckydiabetes.net

KENTUCKY ASSOCIATION of DIABETES EDUCATORS
KADE
Bluegrass/Eastern Chapter
www.kadenet.org

GLADE 1984 — Greater Louisville Association of Diabetes Educators
www.louisvillediabetes.org

Kentucky Diabetes Prevention and Control Program — KDPCP
* [redacted]

JDRF Juvenile Diabetes Research Foundation International
dedicated to finding a cure
www.jdrf.org/chapters/KY/Kentuckiana
1-866-485-9397

DE Cincinnati A
Diabetes Educators Cincinnati Area
www.aadenet.org/AboutAADE/Chapters.html

AACE American Association of Clinical Endocrinologists
Ohio Valley Chapter
www.aace.com

Kentuckiana Endocrine Club
** [redacted]

* The Kentucky Diabetes Prevention and Control Program has a new updated website. Please visit KDPCP at www.chfs.ky.gov/dph/ach/diabetes.
** Kentuckiana Endocrine Club email address is joslin@fmhhs.com